THE PSYCHODYNAMICS OF SUICIDE*

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THE SCIENCES of sociology, anthropology, epidemiology, and demography have contributed extensively to our knowledge of suicide by delineating the milieu in which suicide occurs and by the study of those environmental factors—cultural, social, economic, political, and religious—which influence the prevalence of suicide.

These findings lend even more urgency to the question of the *individual determinants* that operate within the environment to produce suicide—for surely suicide is a highly *individual, personal act.*

Sociologic theory, particularly that which prevailed at the turn of the century, held that suicide reflects the impact of society on the individual. This view is now recognized as inadequate, primarily because it does not attempt to account for the fact that one person seeks self-destruction while another, in similar circumstances and with equal provocation, does not. Thus while external conditions and group patterns operate as inhibiting or encouraging factors, it has become clear to all students of the problem that suicide is essentially a personal reaction. As such, it can be accounted for only in terms of intrapsychic events that constitute the essential, final pathway to the suicidal act.

In his recent book, *Suicide, a Sociological and Statistical Study*, Louis Dublin[1] writes: "The suicidal drive in the last analysis is from within the individual, rather than from without. Suicide is the terminal act in a complicated psychic drama, the final response of a person to his own needs, desires, and circumstances. External events may precipitate that act, and in certain circumstances such as mass suicide in the face of persecution, may dictate it. Countless persons faced with

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what appear to be the same provocations, do not commit suicide. The primary impulses which lead to suicide lie hidden in the depths of the individual's personality."

Viewed as the end product of a series of psychic events it becomes apparent that suicide is not an illness but a symptom that may occur in the course of any of several types of mental illness: depression, either neurotic or psychotic, schizophrenia, and hysteria.

Is suicide invariably the outcome of mental illness or can it occur in the absence of psychic disorder? Some authors have designated the term "normal suicide" for acts of self-destruction committed under circumstances of extreme stress and hopelessness. Examples would include suicide among concentration camp prisoners and among those suffering from painful and fatal disease. Closer examination of such cases, we believe, would reveal that here we are dealing with individuals who have reacted to shattering extrapsychic stresses with depression of inordinate intensity. The fact that most concentration camp prisoners and most sufferers from terminal, neoplastic disease do not attempt suicide lends support to this view.

Psychic Mechanisms that Lead to Suicide

The human psychic apparatus strives constantly to achieve pleasure through the gratification of instinctual needs and to avoid pain. For these purposes, it has access to a number of unconscious devices that arrange for the matching of inner needs with the opportunities for gratification provided by the environment. While innate instinctual sequences are employed for these purposes by lower animals, humans are able to create novel behavioral patterns by bringing great plasticity and flexibility to bear upon the behavioral elements with which they are endowed. Unfortunately, this flexibility may permit the mechanism to miscarry, so that, operating in the face of certain combinations of inner drives and external events, it may lead not to adaptation but to suicide. Let us consider some of the more common instances of such malfunction.

1) When an individual suffers severe pain, he bends every effort to disengage himself from the source or, more precisely, from the apparent source of the pain. The apparent source may be realistically recognized as a frustrating object. On occasion, however, when the actual object is not available for attack, the experience of pain may be

blamed upon the organ of perception or upon the perceiving self. At times, when the patient is so disturbed as to tolerate such illusions, self-destruction may even seem to be equivalent to the destruction of the object.

A patient discussing the thoughts and emotions that preceded a serious suicide attempt said, "For a while I thought that by killing myself I'd make my mother sorry and guilty for the way she treated me. But then I realized that that was ridiculous, because she'd probably be glad if I was gone." I (S.F.) commented that her second thought must have made the idea of suicide much less attractive. "Oh no," she replied, "I'd still be getting rid of her!"

2) Intolerable inner pain may be dealt with by the attempt to eliminate the locus or site of the pain. Patients suffering from causalgia often beg for the amputation of the painful member, and animals are known to chew off their own diseased limbs. The offending part is literally attacked and, if possible, destroyed. Severe depression is characterized by intolerable, inner, psychic pain, and suicide may appear to be a desirable means of eliminating it. The melancholic individual wishes for death as a release from anguish. In less extreme form, this accounts for banging of the head and similar attacks upon the self commonly seen in cases of agitated depression.

3) A child knows that his helplessness and suffering will evoke concern and care from his parents. Children whose demands for attention and care are unmet, have been observed to beat or harm themselves in an effort to elicit concern and love. Suffering adults also may exploit this method of obtaining a desired response from the loved individual who represents a parent by injuring or even destroying themselves.

A 49-year-old man was evicted by his wife who declared that she could no longer live with him because of his incessant, unreasonable demands and his temper tantrums. When his urgent pleas for reconciliation were rejected he began to threaten suicide. This, too, did not have the desired effect. One evening he remained at his office after hours, and there took a huge dose of barbiturate. He was found dead the next morning on the steps leading from his office to the street.

4) Similar in form, but differing in motivation from the mechanism just mentioned, is another in which hostility and death wishes originally directed toward an object come to be turned against the self. Since the disappointing object is loved as well as hated, hostility against him can-

not be directly expressed. Guilt arising from this hostility and an inhibition against killing in general both combine with the ambivalence to deter overt attack. Here suicide presents itself as a method of discharging the aggression without physically injuring the object while still taking revenge upon him, since the object is likely to hold himself responsible for the death.

Here the motive for suicide is quite clearly revenge against the disappointing object. In the mechanism mentioned above, namely hurting oneself in order to compel care and attention, reconciliation, not aggression, is the motive.

5) Erotogenic masochism, as is well known, involves the sexual wish to suffer pain or injury, or both. Freud,[2] who studied this problem extensively, came to the conclusion that primary erotogenic masochism is derived from an imperfect fusion of the destructive or death instinct with libido. This is confirmed by numerous case reports of masochists who have died as a result of self-inflicted sexual mutilation. Here the mechanism leading to suicide is seen to operate directly in the service of a derivative of instinctual drives.

6) Finally, in discussing the role of instincts in relation to suicide, mention must be made of the death instinct. Little is known about this drive since it operates silently, that is, it gives rise to no unique, direct, and obvious psychic representations. In fact, many psychiatrists and psychoanalysts doubt the existence of a primary drive toward death. Freud[3] postulated a death instinct because he found that ultimately he could not account for the insistent destructiveness of aggression, sadism, and masochism in any other way. We have each observed individuals who seemed irresistibly driven to self-destruction. They appeared to be dominated by a primary force which operated independently of, and above and beyond, any immediate considerations of gratification or frustration of libidinal drives. We attribute these clinical states, which very frequently terminate in suicide, to the operation of a death instinct. Others disagree, arguing that one cannot assume such an entity unless it can be demonstrated that its derivative aggressiveness presses constantly for discharge without requiring any external trigger. We believe that such a criterion cannot properly be applied since many instincts do not become active without the operation of a trigger of some kind. However, since psychic pain and distress are ever present to some degree, they serve as a constant and ubiquitous trigger. From a practical

point of view, therefore, destructiveness presents itself everywhere, creating mental illness among other manifestations and, often, suicide.

Fantasies That Favor Suicide

Fantasy formation in essence is the result of the interplay between psychic mechanisms on the one hand and important wishes and memories on the other. The form taken by the fantasy is determined by the mechanisms, while the ideational content is contributed by the wishes and memories. The role of fantasies, both conscious and unconscious, in determining human behavior and motivation, is too well known to require elaboration. Of interest here are those which anticipate suicide. Some of them are so consistently associated with suicide that they may serve as indicators of concern with it.

1) *Identification with a lost object.* Identification occurs in individuals whose object relations are characterized by the need to feel the same as—to be one with—the object. By identification, the distance between subject and object is abolished. In sublimated form, identification gives rise to feelings of loyalty. When a love object with whom one has identified dies, or when there is a strong wish to identify with one who is dead, suicide may present itself as a means for reestablishing sameness, for reuniting the fates of subject and object. The fantasy of identification in death with lost objects probably accounts for most of the so-called "anniversary suicides," and, to a certain extent, for the unusual prevalence of suicide in certain families. A patient who had lost his father, grandfather, and two brothers by suicide and was himself suicidal reported the suicide of yet another brother with the terse remark, "This is the way we do it." Here we see not only identification in death, but identification in the manner in which one dies.

2) *Rebirth.* The fantasy of being reborn, of "starting all over again" occurs, at one time or another, almost universally. It is particularly prominent and clinically significant at the beginning of recovery from acute episodes of schizophrenia and from melancholia. Commonly, a patient who wishes to die will attempt to make death more acceptable by persuading himself that it is a preliminary to rebirth, that is, that death will bring not only relief but repair and renewal. The patient seems to say, "After I end this life, I can begin a new one." As a resident at the New York State Psychiatric Institute, which overlooks the Hudson River in the vicinity of the George Washington

Bridge, I (S.F.) encountered three patients with precisely the same fantasy: "I will escape from this place, run out on the bridge, jump off and drown, and later come out alive and new on the other side."

It is not surprising, therefore, that most religions which hold forth the promise of an afterlife which is, in effect, a rebirth, deny this reward to those who would gain it by suicide.

3) *Reunion with mother.* The regressive wish to be reunited with the giving, protecting mother of earliest infancy finds expression in the fantasies of many deeply disturbed individuals. The patient longs for an ideal state, characterized by passivity, helplessness, and the relative absence of disturbing stimuli arising from within or from without. In the unconscious, death may be endowed with these qualities. At times the fantasy assumes the form of wishing to return to mother's body and to live there. The formal resemblance between the image of inhabiting mother's body and the state of being interred makes the wish to die more compelling. Thus the wish to return to a very early anaclitic relationship becomes the bearer of the wish to die. An increase in the intensity of the wish to return to mother in this way, for example, occasioned by frustration or disappointment in object relations, brings with it an increase in suicidal danger.

4) *Escape.* To those suffering the misery of depression or psychosis, death may appear to be a release from suffering. Although this idea may occur at any age, it is probably more common among older, depressed individuals who have become preoccupied with the thought that they have lost all that is important to them, and that life is therefore no longer worth living.

Ancient and elegant documentation of this fantasy is found in the *Book of Job.* Reduced from great wealth to poverty, bereft of all his children, his body covered with boils, Job says (3: 20-22):

> Wherewith is light given to him that is in misery,
> And life unto the bitter in soul—
> Who long for death, but it cometh not
> And dig for it more than for hid treasures,
> Who rejoice unto exultation,
> And are glad when they can find the grave.

5) *Splitting of the self-image.* In predisposed individuals intense intrapsychic pressures may induce a defensive splitting of the self-image, commonly into a "good" and a "bad" self. The former image is ego

syntonic, the latter ego alien. This splitting may give rise to a number of consequences. Depersonalization is a common result of splitting. In melancholia the image of the self is often divided into two portions. The "bad" fragment remains within the ego and becomes the target of the melancholic's relentless, punitive superego with which the "good" fragment identifies. The patient may speak of a demon clawing away at his insides. The resulting inner pain and tension may be so great as to lead to suicide in a desperate attempt to eliminate one of the protagonists. The associated fantasies indicate that either the harsh punitive superego or the unacceptable "bad self" may be the primary target of the suicidal impulse.

In an attempt to ward off a threatened breakthrough of poorly repressed, incestuous wishes, a young woman moved out of her parents' home. Shortly thereafter she became depressed and reported the following dream: "My father and I are standing at the window of our old apartment with loaded shotguns. We are waiting for 'another me' to emerge from the entrance of a building across the street. Finally, the 'other me' comes out, and we fire. I awake in terror."

6) *Autoscopy*. Actually this last example relates to a similar phenomenon of waking life, autoscopy. Here the patient describes encountering an image of himself while awake. The image may be an hallucination, an illusion, or a vivid fantasy. More than 60 years ago Rank[4] suggested that in adult life the double appears as a harbinger of death. This hypothesis is supported in a paper by one of us (M.O.) on the metapsychology of autoscopic phenomena,[5] in which several autoscopic phenomena are reported, including the following.

While walking home from an analytic hour, a depressed patient felt weary and stopped to lean against a tree. He felt that he wanted to stay there, and at the same time he could visualize an image of himself continuing to walk home. "I wanted just to stand there, and let another part of me carry on." When questioned, he said, "Yes, I wanted to die."

About a week later the same patient reported another autoscopic incident. As he sat alone in his room reading, it seemed to him that "another one of me goes to the medicine closet and takes an overdose of sleeping pills."

In the first autoscopic incident it is the observing self who is to die while the observed image goes on living. In the second, the roles are interchanged.

7) *Revenge.* Finally, and perhaps best known, are the fantasies in which suicide represents the ultimate act of revenge aimed at a disappointing object, or a real or imagined persecutor. Here, in effect, suicide is homicide which has been turned against the self. The interplay between murderous impulses and suicidal drives and, in particular, the mechanisms whereby one is interchanged with the other, were not understood until Freud formulated his theory of sadism in *Mourning and Melancholia* in 1917,[6] by which time the vicissitudes of aggression were more clearly recognized. Freud postulated that in pathologic depression the subject identifies with a hated and loved object. The identification, or psychic incorporation, expresses the love. When, as a result of loss, disappointment, or rejection, the love turns to hate, the tendency to suicide may become overwhelming. By destroying himself, the subject also destroys the object, who is inside him and yet remains united with him. If, in addition, there is guilt toward the object, suicide becomes even more appropriate and compelling. For then, in a single act, not only is the object destroyed, but the guilty self is justly punished for hatred and murder.

The jilted lover or the deserted spouse who dies at his own hand may perhaps leave a note which not only names the target of the suicide, but states that the motive was revenge. "You made me do this —and my blood shall be on your hands forever," read one such note.

With regard to the determinants of suicide just discussed, it should be added that they are not mutually exclusive. Generally, one or more mechanisms and one or more fantasies which express the mechanisms may exist. Suicide therefore is usually an overdetermined act. In fact, the likelihood of a serious attempt and a fatal outcome increases directly with the degree to which the impulse to suicide is overdetermined.

Mechanisms of Suicide in Various Disease Entities

From the hypothesis that suicide is the product of mental disorder, one may infer a corollary, namely that the mechanism of the suicide will relate to and derive from the psychodynamic pattern of the disorder which generated it.

Typically, in schizophrenia and hysteria, the dynamic problem centers around the need to disengage from a pain-provoking object. The object gives rise to pain instead of pleasure either because he rejects and disappoints, or because he represents a forbidden temptation.

The schizophrenic's need to detach himself from objects finds expression in his fantasies of world destruction. He exchanges perceiver and percept and so destroys the world by destroying himself. The paranoiac may kill himself in order to avoid falling into the hands of his persecutors. When we recall that the persecutors in paranoia were originally loved homosexual objects, we see that his suicide is determined by the need to prevent the breakthrough of repressed, unacceptable impulses. The suicide committed at the height of homosexual panic, in the absence of a delusionary system, is of course similar and more transparent.

A usually passive young man was hospitalized following a vicious, unprovoked assault on his father. His initial warm, friendly feelings for his male therapist unaccountably changed to dislike and then to aversion. He became convinced that his doctor was harming rather than helping him, and his anxiety in the latter's presence rapidly increased to the point of panic. When his repeated demands for a change of therapist went unheeded, he managed to escape from the hospital and promptly threw himself under a passing truck.

For the hysteric, the tempting but forbidden object is usually an incestuous one. As often as not, the detachment must be effected from one who has become the psychic representative of the parent or sibling. In reality, the object involved may be a spouse, child, or friend. Much of the marital and family discord suffered by hysterics is attributable to this need to disengage. If severe enough, it may leave suicide as the only solution.

A man was carrying his beloved daughter around his apartment. As he passed an open window, he suddenly threw the baby out, and then jumped after her.

The psychodynamics of pathologic depression have been touched upon several times in this discussion, and classical theory requires only brief recapitulation here. Both normal and pathologic depression are precipitated by a loss. In normal depression (mourning) the ties to the lost object are gradually severed and, when this task is completed, the subject is free to reach out for new objects. In pathologic depression this does not occur because the lost object has been both loved and hated. The aggression now gives rise to guilt, which makes it impossible to dissolve the ties, and enforces the continued identification with the object. The psychicly incorporated image—the introject—cannot be

eliminated. The relentless self-accusation and self-depreciation of the melancholic thus are directed not only at himself but, more significantly, at the hated introject. This, as well as the resulting inability to undo the loss by turning to new objects, gives rise to the feeling of emptiness and severe inner pain characteristic of depression. The ensuing suicidal impulses may therefore be triply determined. The guilty self is to be punished; the tormenting introject will finally be eliminated; and the inner pain will be abolished. It is this overdetermination that makes suicide such a serious threat in pathologic depression.

Following the death of his wife, a 58-year-old man became depressed. Instead of abating with the passage of time, his morbid state deepened. He was unable to return to work, shunned friends and relatives, and spent most of his time brooding and weeping. When forced to visit a psychiatrist, he first spoke of how close he and his wife had been, how they had done everything together (they had no children), and of his feeling that he could not go on without her. Later his verbal productions dealt almost exclusively with occasions when he had mistreated or failed her. In a delusional way he insisted that he had not done all he could for her in her terminal illness and therefore was responsible for her death. For this he could never forgive himself. To the feeling that life was no longer worth living was added the conviction that he did not deserve to live. Despite intensive psychotherapy and pharmacotherapy his condition continued to deteriorate. Arrangements for hospitalization were made, but on the morning of his scheduled admission he was found dead in his apartment.

Finally, mention should be made of suicides that occur in consequence of pathologic influences but in the absence of any clear-cut diagnostic entity. Typically these stem from a real or imagined rejection at the hands of an object who was relied upon to fulfill needs for emotional support. Here the patient feels the loss of the object just as an infant would feel abandonment by its mother. Elements of resentment and revenge may play a role, but the prime determinant is the feeling of helplessness and panic at the prospect of facing life alone.

The husband of a mild, passive, middle-aged woman stayed out late one night without notifying her. Unable to locate him, she feared desertion, was overwhelmed by separation anxiety and, at the height of her panic, impulsively swallowed a bottleful of pills. Until this time she had shown no signs of organized, clinically definable psychopathology.

The Psychology of the Suicidal Act

We have concerned ourselves to this point with the psychology of suicidal motivation. In this final section, the psychology of the suicidal act itself will be briefly discussed.

Suicidal acts are rightfully evaluated in terms of *seriousness of intent.* As is well known, the range is quite broad. At one extreme is the unhappy teenager who swallows five aspirin tablets and, at the other, the melancholic who leaps from the top of a skyscraper. The degree of seriousness is determined by two factors: 1) intensity of the motivation and the extent to which it is overdetermined; and 2) the degree to which the urge to self-destruction is diluted by the presence of libidinal, life-preserving energies.

We suspect that no suicidal act is completely conflict-free, that is, totally devoid of any urge to live. Even in extreme cases it is present, and it weakly and ineffectually opposes the destructive forces.

Conversely, the significance of the most benign suicidal gesture should not be underestimated. The facts that the idea did occur and that the gesture was made betrays the existence of the tendency to self-destruction. Under more adverse circumstances the latter might easily be activated in more urgent form and with serious consequences.

The method chosen for accomplishing the suicide is a relative indicator of seriousness of intent. Thus, other conditions being equal, a bit of iodine spells lesser motivation than does jumping from heights.

More important is the fact that the method chosen is usually related symbolically to the fantasy that underlies the suicidal impulse. *How* he does it tells us a great deal about *why* he does it.

In general, the unconscious seems to believe that the punishment should fit the crime. The patient generally chooses a method of dying which represents either an extreme variant of or the opposite of the fantasied crime for which he punishes himself.

For example, in his dreams and fantasies the male homosexual will see himself shot or stabbed to death. This image represents the carrying of his wish to be attacked by another man's penis, to a lethal extreme. It is also the converse of an associated wish, to attack another man with a lethal penis. Such an individual, if he is bent on suicide, will stab or shoot himself, or arrange, for example, by exposing himself to danger and by provoking attack, to be stabbed or shot by someone else.

Similarly, for many phobics, Oedipal guilt is associated with fantasies of climbing or flying too high, or of phallic erection under improper circumstances. The retaliatory punishment involves falling from heights, being pushed down, or jumping, and these then are preferred modes of suicide for such individuals. The depression which antecedes the suicide is associated with feelings of a drop in self-esteem, of humiliation, and of being "brought low."

For some individuals the sensation of heavy breathing, which is associated also with sexual excitement, becomes an erotic experience. When the threat of loss of control of erotic impulses creates anxiety and, with it, breathlessness, the latter is accompanied by the specific fear of suffocating. Hanging is a preferred mode of suicide among such individuals. Drowning represents not only suffocation, but also rejoining mother, by immersion in what becomes literally a fluid *matrix.*

Taking an overdose of medication is, in effect, death by the ingestion of poison. Psychoanalytic investigation of individuals who have attempted or later committed suicide by poisoning leaves little doubt that the act stemmed from disappointment in an anaclitic or dependent relationship. It is as if the suicide's final words are to the effect: "You are a bad mother. You were supposed to care for me and feed me well, but you fed me poison."

Those individuals who find sexual excitement in smelling the love object, as the infant detects and enjoys its mother by her smells, prefer the inhalation of poisonous gases as a mode of suicide. Since the strongest odor of childhood is the fecal odor, such individuals are prone to fixation at the anal phases of psychosexual development. They are likely to enjoy fantasies of identifying with the lost mother or mother-surrogate by the fantasy of incorporating her by inhalation. Therefore just as the oral individual, disappointed in feeding by the mother, will poision himself, the anal individual, disappointed by her absence, or rather by the absence of her odors, will inhale poisonous gases.

Cutting oneself is the favored mode of suicide among those individuals who deal with excessive sexual excitement with fantasies of cutting the genitals, their own or their partner's. Another form of cutting, less physical, is detaching oneself psychically from the love object or from an offending organ, as in hysteria, or from the entire world of reality, as in catatonia.

In addition to discrete suicidal acts, there are the slow or partial

suicides. Included here are alcoholism and other addictions, compulsive gambling and, in certain circumstances, unnecessary heroism. In another category are those suicides in which the agent is projected onto the outside. Death is made to appear as though it came from without, or by chance. Russian roulette in its various forms is one. Life-endangering occupations or acts are another. Here one thinks of the race-car driver, the bullfighter, and the stunt man. Serious accident-proneness is a third and more common category. When a friend asks the reckless driver, "What are you trying to do—kill yourself?" he may be more rhetorically correct than he suspects. In each instance a relation exists between mode of self-destruction and motivating fantasy, and it is specifically determined.

Fortunately, all suicidal acts do not terminate in death—and this brings up a final question. What can be said about the psychology of the aftermath of a suicide attempt?

The reactions of would-be suicides to their failures fall into two rather distinct categories. In one there is depression and disappointment in the discovery that the attempt has failed. A deeply depressed patient, in speaking of a recent suicide attempt said, "I suppose it's like tennis; you don't get it right at the first attempt. With practice, though, you improve, and finally succeed." Needless to say, this reaction carries a highly unfavorable prognosis.

The second type of reaction encountered is essentially the converse of the first. There is elation and a feeling of reprieve from a situation of danger. The failure may come to represent the gratification of the wish to be rescued, and may be accompanied by the feeling of being reborn. In some instances, the suicidal intent, or even the suicidal act itself, may be denied. Though more favorable prognostically, the elation following failure is usually short-lived. Unless corrective measures are taken, the intra- and extrapsychic factors which motivated the first attempt may well reassert themselves with undiminished intensity—bringing with them renewed danger.

Therapy

A discussion of the treatment of the would-be suicide lies beyond the scope of this paper. Obviously, though, since suicide is not a disease in itself, but a manifestation of disease, it is the latter which must

be treated. Generally, perhaps usually, the evolution of the illness to the point at which suicide presents itself as an irresistible attraction may be prevented or at least retarded by psychoanalysis when the latter is undertaken early enough and, to a lesser extent, by the less thoroughgoing psychotherapy. When psychoanalysis or psychotherapy fails, or when the patient fails to present himself for treatment until the disease is too far advanced to be subject to such influences, the newer drugs can now often be used to exert some control over an otherwise desperate situation. The proper use of these agents is difficult, requiring experience, patience, ingenuity, and courage, and their power is only relative and far from permanent. Moreover, while they may correct a regressive process at an advanced phase of illness, they cannot combat the illness itself nor undo the pathogenic process. Their most elegant use in the individual case is to provide relief while the analyst works to get hold of the disease process and to interfere with its unremitting progress and destructive tendency. Such intensive and refined care can be made available only to a few, so that for the large majority of suicidal patients, major reliance must be placed upon these powerful medications.

Electroshock therapy exerts a more powerful and speedy therapeutic influence than the energizing drugs, but the latter can be used over an extended period of time when necessary, whereas the former is necessarily limited to relatively brief, circumscribed courses.

Summary

Suicide, when it occurs, is the outcome of a disease process which has prevailed for a considerable period of time previously. The factors which bring it about are essentially two. First, there is a drive to destructiveness, which Freud saw as the manifestation of a death instinct or a set of death instincts. Second, there is a set of mechanisms that normally function to increase by several orders of magnitude the flexibility and plasticity of instinctual behavior but which, when they miscarry under the influence of disease, serve to reflect destructive instincts away from external objects and back upon the self.

In this brief essay, we have tried to enumerate and describe some of the more common of these mechanisms. Furthermore, these mechanisms operate unconsciously, but they achieve representation in conscious or preconscious thought by creating fantasies. The fantasies

seem to explain or justify the suicide and also to make it more attractive or, at least, less frightening. We have listed, described, and illustrated some of the more common of these fantasies too.

Of course, the mechanisms which lead to suicide constitute in each case a portion of the repertoire of instinctual mechanisms of each individual. Since it is this same repertoire which determines the form of the antecedent illness, we can expect to find a relation between the psychodynamics of this illness and the mechanisms and fantasies of suicide which evolve. We have tried to spell out a few of these relations.

When the mechanisms and fantasies that we have here described appear in the course of an illness, we must alert ourselves to the possibility of suicide. And when they disappear, we may infer that the danger of suicide has receded.

Finally we have drawn attention to a corollary of our discussion, namely, that the treatment of the suicide complex is the treatment of the underlying disease. Since definitive psychoanalysis, which is still our most effective, long-range therapy, is a slow and inefficient procedure at best, even when applied early in the course of the illness, since the same is true in even greater degree of the lesser psychotherapies, and since patients seek assistance in their struggle with suicide only relatively late in the course of illness, the newer drugs and, in a few instances, electroshock therapy have offered welcome assistance in the management of the suicide threat. While practical considerations may limit treatment to these chemical and electrical modalities, the psychiatrist must realize that their influence is symptomatic and usually temporary. Unless psychoanalysis, or one of the psychotherapies, taking advantage of the respite offered by these other procedures, succeeds in retarding the pathogenic process, the suicide threat will recur time after time.

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